Department to obtain sufficient data for a full twelve month base cost reporting period allowed under Section 1.302. In those rare instances where it may be impossible to obtain the prior owner's cost report, the Department may determine it is not needed if the cost reporting period for the new owner allowable under Section 1.302 covers a period of at least six months. If the prior owner's cost report is needed, but not submitted, the new provider's rates for the payment rate year specified in Section 1.130 will default to the facility's June 30th rate of the prior payment rate year, exclusive of any amounts for ancillary add-ons and Nursing Home Appeals Board awards and special allowances for local government operated facilities. The Department may reduce those rates by no more than 25.0% if deemed appropriate.

4.230 Property Tax. The property tax allowance shall not be adjusted to recognize a change in tax status upon a change of ownership.

4.300 PAYMENT RATES FOR NEW FACILITIES

4.301 General. Payment rates for a new facility will be established under the rate calculation provisions of Section 3.000. The rate computation will consist of two phases: (1) retrospective rates for the start-up period, and (2) post start-up period adjusted rates. The Department will establish interim rates until rates can be finalized under this section. New facilities are defined in Section 1.305. The Department may deny approval of any rates if any required Chapter 150 approval was not obtained. The Chapter 150 rate maximum per Section 1.600 shall apply, if applicable, to the new facility. Allowable costs will be deflated and inflated as appropriate with the indices in Section 5.300 and the provisions of the current Methods applied. The property allowance shall be calculated under the provisions of Section 3.500.

The provisions of Sections 4.300 through 4.360 shall not apply to the full or partial conversion of an NF to ICF-MR certification.

4.310 Start-Up Period. The start-up period shall be the twelve-month period beginning on the first of the month following the month in which the facility was licensed. A facility certified for the Medicaid Program after this twelve-month period shall be considered to have completed its start-up period.

4.320 Payment Rates During the Start-Up Period. Payment rates for the start-up period shall be retrospectively established based on one or more cost reports for the start-up period. The cost reporting period shall: (1) begin on, or within the five calendar months after, the date of certification for Medicaid, and (2) end on, or within the five calendar months after, the end date of the start-up period. The payment rates shall not be effective earlier than the certification date and shall lapse not later than at the end of the start-up period.

The minimum patient days for the administrative expense component (Section 3.230), the fuel and utility allowance (Section 3.300), the property tax allowance (Section 3.400), and the property allowance (Section 3.500) shall be the greater of patient days at 50.0% occupancy of average licensed beds or adjusted patient days during the cost reporting period.

4.330 Payment Rates After the Start-Up Period. After completion of the start-up period, rates for a new facility shall be reestablished based on at least a six-month cost report which will begin after the end of the start-up period or after the end of the cost reporting periods used under Section 4.320. The minimum patient day occupancy standards under Section 3.000 shall apply.

4.332 Modified Cost Report Period. The Department may modify the above start-up period and cost reporting requirements for special situations or to accommodate the fiscal year of a provider to permit more efficient or reliable cost reporting. Whenever possible, fuel and utility expense should cover a twelve-month period pursuant to Section 3.360.

4.333 Base Rates. The base rates for a newly-licensed facility are described in Section 3.722, item 4.

4.335 July 1 Payment Rates. A base cost reporting period shall be designated by the Department for establishing a new facility's payment rates for July 1 of the payment rate year described in Section 1.314. If the start-up period includes the July 1 date, then the July payment rates shall be established under the retrospective provisions for the start-up period. If the cost reporting fiscal year specified in Section 1.302 begins before or during the start-up period, then the Department may designate a more current base cost reporting period for July rates.

4.350 Inflationary Adjustment of Expenses. Cost data from any cost reporting period described above will be inflated or deflated to the common period described in Section 1.303.

4.360 Property Tax Allowance. The property tax allowance shall be based on the provisions of Section 3.400. Nevertheless, the provider may request the property tax allowance for a new facility to be adjusted if the expense in the previous tax allowance had been based on an assessment date prior to the month of licensure. The adjustment shall be effective on January 1 of the year in which payment of the tax or municipal service fees are due but not earlier than the first of the month in which the request is received by the Department. The adjustment shall only consider current expenses, without any inflationary adjustment, and patient days from the cost report period that was used for the support services allowance in the January 1 payment rate.

4.400 PAYMENT RATES FOR SIGNIFICANT INCREASES IN LICENSED BEDS

4.401 General. The Department may require or a provider may request the payment rate to be reestablished under the provisions of Section 3.000 when a provider significantly increases its unrestricted use licensed beds. The rate computations will consist of two phases: (1) retrospective rates for the start-up period, and (2) post start-up period adjusted rates.

The Department may establish interim rates until rates can be finalized under this section. A significant increase in licensed beds is defined in Section 1.304. The Department may deny approving any adjusted rates if any required Chapter 150 approval was not obtained. The Chapter 150 rate maximum per Section 1.600 shall apply, if applicable, to the expanded facility. The property allowance shall be recalculated under the provisions of Section 3.500.

The provisions of Sections 4.400 through 4.460 shall not apply to the full or partial conversion of an NF to ICF-MR certification.

4.410 Start-Up Period. The start-up period shall be the twelve-month period beginning on the first of the month following the month in which the new beds were licensed.

4.420 Payment Rates During the Start-Up Period. Application of this section is optional. Payment rates for the start-up period may be retrospectively established based on one or more cost reports for the start-up period for any or all applicable payment allowances. The cost reporting period shall: (1) begin on, or within the five calendar months after, the beginning date of the start-up period, and (2) end on, or within the five calendar months after, the end date of the start-up period. The adjusted payment rates shall be effective as of the date of amended licensure.

The minimum patient days for the administrative expense component (Section 3.250), the fuel and utility allowance (Section 3.300), the property tax allowance (Section 3.400), and the property allowance (Section 3.500) shall be the greater of adjusted patient days or patient days at the minimum occupancy rate described here. The minimum occupancy rate shall be based on: (1) 50.0% of the increase in licensed beds, and (2) the average daily occupancy in the six calendar months immediately preceding the increase in licensed beds during which no substantial number of licensed beds were out-of-use due to any renovation or construction. The occupancy rate in (2) above must be 91% or greater.

4.430 Payment Rates After the Start-Up Period. After completion of the start-up period, rates for a significantly expanded provider may be reestablished based on at least a six-month cost report which will begin after the end of the start-up period or after the end of the cost reporting period used in Section 4.420. The minimum patient day occupancy standards under Section 3.000 shall apply. Section 4.430 may be applied to the significantly expanded provider which does not receive a retrospective adjustment under Section 4.420.

4.432 Modified Cost Report Period. The Department may modify the above cost reporting requirements for special situations or to accommodate the fiscal year of a provider to permit more efficient or reliable cost reporting. Whenever possible, fuel and utility expense should cover a twelve-month period pursuant to Section 3.360.

4.433 Base Rates. The base rates for a significantly expanded facility are described in Section 3.722, item 3.

4.435 July 1 Payment Rates. A base cost reporting period shall be designated by the Department for establishing an expanded facility's payment rates for July 1 of the payment rate year described in Section 1.314. If the start-up period includes the July 1 date, July payment rates may be established under the retrospective provisions for the start-up period. If the cost report for the fiscal year specified in Section 1.302 begins before or during the start-up period, the Department may designate a more current base cost reporting period for July 1 rates.

4.460 Property Tax Allowance. The property tax allowance shall be based on the provisions of Section 3.400. Nevertheless, the provider may request the property tax allowance for an expanded facility to be adjusted if the expense in the previous tax allowance had been based on an assessment date prior to the month of licensure. The adjustment shall be effective on January 1 of the year in which payment of the tax or municipal service fees are due but not earlier than the first of the month in which the request is received by the Department. The adjustment shall only consider current expenses, without any inflationary adjustment, and patient days from the cost report period that was used for the support services allowance in the January 1 payment rate.

4.500 PAYMENT RATES FOR SIGNIFICANT DECREASES IN LICENSED BEDS

4.501 General. A provider may plan to significantly decrease its number of unrestricted use licensed beds. The Department may require or the provider may request payment rates to be reestablished. If the provider makes the request, the provider must notify the Department in writing prior to the effective date of the reestablished rates and must relinquish the future use of a significant number of licensed beds. Any

future use of the relinquished beds must be approved, if required, under Chapter 150, Wis. Stats. The Department may deny rate adjustments under this section if it determines the provider's decrease is not desirable or appropriate.

If the reduction involves an extended and major phase-down, the provider may elect to have rates established under the provisions of Section 4.560 below. If Section 4.560 is not applied, the rate computation will consist of two phases: (1) retrospective rates for the phase-down period, and (2) post phase-down adjusted rates. A significant decrease is defined in Section 1.304. The property allowance shall be recalculated, subject to the targets, maximums and ratios described in Section 3.500.

The provisions of Sections 4.500 through 4.560 shall not apply to the full or partial conversion of an NF to ICF-MR certification.

4.501(a) Sale of Beds. A rate adjustment will be made under this section only when a provider has surrendered the right to license these beds for reallocation through the Resource Allocation Program (RAP). Thus, where a provider has sold or transferred his right to license beds, without going through the RAP process, the phase-down and facility closing provisions will not be used to adjust Medicaid rates for the facility that is reducing licensed bed capacity.

The costs of acquiring the right to license beds from another provider are non-reimbursable costs.

4.510 Phase-Down Period. The phase-down period is that time period during which the resident population may be reduced and during which licensed beds are being reduced to the objective bed capacity. The provider shall submit a written plan for the phase-down acceptable to the Department. The plan must specify the objective licensed bed capacity, the expected date by which any phase-down of the resident population is to begin, the amount of the phase-down, and the expected date by which the license will be amended to the objective capacity. The Department shall establish the beginning and ending dates of the phase-down period which may be modified as needed during the phase-down.

4.520 Payment Rates During the Phase-Down Period. Application of this section is optional. Payment rates for the phase-down period shall be retrospectively established under Section 3.000 based on one or more cost reports. No retrospective adjustment shall be available if the phase-down period is less than six months. The cost reporting period(s) shall: (1) begin on, or within the five calendar months before or the five calendar months after, the starting date of the phase-down period, and (2) end on, or within the five calendar months after, the effective date of the amended license at the objective capacity. The retrospective payment rates shall not be effective earlier than the beginning date of the cost reporting period and shall lapse at the end of the reporting period.

The minimum patient days for the administrative expense component (Section 3.250), the fuel and utility allowance (Section 3.300), the property tax allowance (Section 3.400), and the property allowance (Section 3.500), shall be the greater of patient days at 96.0% occupancy of the objective licensed bed capacity or adjusted patient days during the cost reporting period.

4.530 Payment Rates After the Phase-Down Period. After a provider's license is amended to the objective licensed bed capacity, payment rates may be reestablished based on at least a six-month cost report acceptable to the Department which will begin after the end of the phase-down period or after the end of the cost reporting period used under Section 4.520. Section 4.530 may be applied to the significantly decreased provider which does not receive a retrospective adjustment under Section 4.520. The minimum occupancy standards in Section 3.000 shall apply for determining payment rates after the phase-down period.

4.532 Modified Cost Report Period. The Department may modify the above cost reporting requirements for special situations or to accommodate the fiscal year of a provider to permit more efficient or reliable cost reporting. Whenever possible, fuel and utility expense should cover a twelve-month period pursuant to Section 3.360.

4.535 July 1 Payment Rates. A base cost reporting period shall be designated by the Department for establishing the decreased facility's payment rates for July 1 of the payment rate year described in Section 1.314. If the phase-down period includes the July 1 date, then the July payment rates may be established under the retrospective provisions for the phase-down period. If the cost report for the fiscal year specified in Section 1.302 begins before or during the phase-down period, then the Department may designate a more current base cost reporting period for July 1 rates.

4.550 Inflationary Adjustment of Expenses. Cost data from any cost reporting periods described above will be inflated or deflated to the common period described in Section 1.303.

4.560 Major Phase-Down. A major phase-down is: (1) a significant reduction in unrestricted use licensed beds, and (2) a reduction of resident population by 15.0% or more. The determination of the extent of the reduction of resident population shall be based on the average daily resident census, including each bed hold day as one full day, during the cost reporting period which would have been used for establishing payment rates in the first month of the phase-down period if no phase-down rate adjustment had been pursued. Payment rates for such a provider shall be negotiated between the Department and the provider. The provisions of Section 3.000 need not be applied for determining such rates.

4.580 FACILITY CLOSINGS

A provider may choose to phase out its nursing home operation. In such cases, the provider may request, or the Department may require, an adjustment to payment rates for the period of the phase-out. The Department may deny rate adjustments under this section if it determines the provider's phase-out is not desirable or appropriate. Payment rates for such a provider shall be negotiated between the Department and the provider. The provisions of Section 3.000 need not be applied for determining such rates.

4.600 CHANGE IN FACILITY CERTIFICATION, OR LICENSURE

4.601 General. If a provider changes its certification, including certification in whole or in part as an ICF-MR or licensure level, the Department may require, or the facility may request, payment rates to be reestablished under Section 3.000. Only the direct care allowance under Section 3.100 and the final rates under Section 3.700 will be recalculated, based on a cost reporting period for patient days and for direct care wages, purchased services and supply expenses. In lieu of reporting new supply expenses, previously allowed supply expenses may be used in the recalculation if acceptable to the Department. The rate computations will consist of two phases: (1) retrospective rates for the change-over period, and (2) post change-over period adjusted rates. The Department may establish interim rates until rates are finalized. The Department may deny reestablishing payment rates if any required Chapter 150 approval was not received. The Chapter 150 rate maximum, per Section 1.600, shall apply, if applicable, to the facility.

4.602 Exceptions. The provisions of Section 4.600 do not apply to a facility certified as a skilled nursing facility (SNF) solely acquiring certification as a nursing facility (NF). Section 4.600 delineates provisions for rate adjustments for facility converting to ICF-MR certification.

4.605 Rates Not Reestablished. If rates are not reestablished upon a change in certification or licensure level, then the payment rate for any added level of care shall be the rate from the next lower level of care.

4.610 Change-Over Period. The change-over period shall be at least a six-month period but no more than a twelve-month period beginning on the first of the month following the month in which the change was effective.

4.620 Payment Rates During Change-Over Period. Application of this section is optional, and if it is not applied, then Section 4.610 will apply. Payment rates for the change-over period may be retrospectively established based on one or more cost reports for the change-over period. The cost reporting period shall: (1) begin on, or within the five calendar months after, the beginning date of the change-over period, and (2) end on, or within the five calendar months after, the end date of the change-over period. The adjusted payment rates shall be effective as of the effective date of the applicable change.

4.630 Payment Rates After the Change-Over Period. After completion of the change-over period, rates for a changed provider may be reestablished based on at least a six-month cost report for patient days and for direct care wages, purchased services and supply expenses. Such cost reporting period shall begin after the end of the change-over period or after the end of the optional cost reporting period used under Section 4.620.

4.632 Modified Cost Report Period. The Department may modify the above cost reporting requirements for special situations or to accommodate the fiscal year end, reimbursement period, or other cost reports required in different sections of these Methods to permit more efficient or reliable cost reporting.

4.635 July 1 Payment Rates. A base cost reporting period shall be designated by the Department for establishing a changed facility's payment rates for July 1 of the payment rate year described in Section 1.314. If the change-over period includes the July 1 date, then payment rates for July through the end of the change-over period may be established under the retrospective provisions for change-over period. If the cost report for the fiscal year specified in Section 1.302 begins before or during the change-over period, then the Department may designate a more current base cost reporting period for July 1 rates.

4.650 Inflationary Adjustment of Expenses. Cost data from any cost reporting periods described above will be inflated or deflated to the common period described in Section 1.303.

4.690 SPECIAL CARE PAYMENTS/NON RATE PAYMENTS

4.691 Ventilator Dependent and Extensive Care Patients. Ventilator dependent patients who can be transferred from a hospital to a nursing home, may be able to receive a comparable level of service at a lower cost in a nursing home. Upon prior approval of the Department,

payment of $350 per day, in lieu of the facility's daily rate, shall be paid for such an individual resident for a period determined by the Department if it has been demonstrated to the satisfaction of the Department that the facility can provide care in accordance with the specific patient's needs. This payment does not apply to patients receiving either Continuous Positive Airway or Bi-level Positive Airway pressure ventilator care. Any such payment or recoupment of same is contingent on care being needed and provided. Payment for related extensive care patients prior authorized for eate at the $150 rate before July 1, 1989 will continue to receive this rate, with appropriate continued prior authorization for the payment rate year.

4.692 Facilities for the Treatment of Head Injuries. Facilities providing specialized treatment for head injuries may receive a negotiated rate, in lieu of the facility's daily rate, for each resident participating in the head injury program. Allowable cost principles and formula maximums may be applied to rate calculations. Rates may be updated periodically to account for changes in facility costs. The treatment program must be approved by the Department based on established criteria for admission, continuing stay, discharge and other program requirements as determined by the Department. Treatment and rates must be appropriate and receive prior approval of the Department.

Persons interested in a rate for treatment of head injured persons should contact: Administrator, Division of Health Care Financing; P.O. Box 309, Madison WI 53701-0309.

4.694 Residents with AIDS. For requests received prior to October 1, 1993, subject to prior authorization from the Department, a provider accepting a resident diagnosed with AIDS or ARC may receive a payment of $150 per day in lieu of the facility's daily rate. A facility may claim bed hold based on the facility's ISN rates for the empty bed in a semi-private room occupied by an AIDS patient, even if the facility does not meet the occupancy requirements for bed hold described in Section 1.510.

For requests submitted or renewed on or after October 1, 1993, subject to prior authorization from the Department, a provider accepting a resident diagnosed with AIDS may receive a payment of $150 per day in lieu of the facility's daily room rate. Subject to prior authorization by the Department, an additional payment equal to 85% of the facility's ISN rate may be provided for the empty bed in a semi-private room if the AIDS resident's clinical condition requires isolation and a private room is not available.

4.695 Exceptional Supply Needs. In addition to the rates described in Section 4.691, payment for exceptional supply needs for ventilator dependent patients and patients receiving similar care may be paid, if prior authorization is received by the Department.

4.696 Isolation Rate. Subject to prior authorization from the Department, and except for AIDS residents under Section 4.694, a facility accepting a resident with a communicable disease requiring isolation pursuant to HFS 132.51(2)(b), Wis. Adm. Code, may receive an additional payment of the difference between the nursing home's private pay rate for a semi-private room and the private room rate up to $35 per day in addition to the Level of Care rate.

4.697 Property Appraisals. The nursing facility shall submit payment for property appraisal to the contractor under Section 3.531 upon receipt of appraisal invoice from said contractor after the Department has approved the appraisal. The nursing facility provider shall receive payment authorized by the Department upon verification of appraisal cost payment from the contractor.

4.700 SPECIAL PROPERTY TAX ADJUSTMENT

The property tax allowance per Section 3.400 may be adjusted when licensed bed areas are added or replaced or when service areas are added or replaced through construction, conversion, or renovation. This adjustment is available for both significant and non-significant bed increases. The provider may request this adjustment to the property tax allowance if the expense in the previous tax allowance had been based on an assessment date prior to the month of completion of the construction, conversion, or renovation. The adjustment shall be effective on January 1 of the year in which payment of the tax or municipal service fees are due but not earlier than the first of the month in which the request is delivered to the Department. The adjustment shall consider only current expenses, without any inflationary adjustment, and patient days from the cost report period that was used for the support services allowance in the January 1 payment rate.

4.800 PAYMENT RATE ADJUSTMENT FOR RENOVATION PERIOD

4.801 General. The payment rates may be retrospectively adjusted when a provider temporarily takes a significant number of licensed bed days out-of-use for the purpose of capital renovation of a portion of the facility. Significant is the lesser of 4500 licensed bed days or 25.0% of the annualized licensed bed days of the facility. The adjusted rates shall be effective only for the period of the renovation but not earlier than the first of the month following the month in which the written request for the renovation rate adjustment is delivered to the Department's Bureau of Health Care Financing. The period of renovation and the number of beds out-of-use must be acceptable to the Department. The period of renovation must be reasonable and will be subject to approval by the Nursing Home Section Chief or delegate upon recommendation from the provider's Medicaid auditor.

4.810 Calculation. The allowances listed below will be retrospectively adjusted for the renovation period in order to consider only the greater of adjusted patient days or patient days at 96.0% occupancy of licensed beds as decreased for the number of beds temporarily out-of-use for the renovation. The adjustment will not consider current expenses, only current patient days for the renovation period. The allowances to be adjusted are the maintenance and security components of the support services allowance (Section 3.200),the administrative expense component of the administrative and general services allowance (Section 3.250), the fuel and utility allowance (Section 3.300), the property tax allowance (Section 3.400), and the property allowance (Section 3.500). See Section 3.722, item 4, regarding base rates.

4.850 Payment for Services Provided During Temporary Evacuation

4.851 General. If a facility is evacuated due to a natural or man-made disaster, pursuant to a declaration by the Governor of a state of emergency, the following provisions will apply. The nursing home will be responsible for the services provided during the emergency. The Department shall provide retrospective payment for extraordinary expenses that occurred on or after the first day of the base cost reporting period and associated with the temporary evacuation. Extraordinary expenses include payments for direct expenses or purchased services for temporary accommodations and emergency repairs to the nursing home, including costs associated with the evacuated residents incurred by other service providers in providing care, treatment, housing and housing-related services for the evacuated residents. Payment for extraordinary expenses are not subject to the formula maximums under Sections 3.100 through 3.700.

4.852 Payments. The Department will provide prospective payment during the evacuation period and retrospective payment for extraordinary expenses after the evacuation period.

4.8521 Prospective Payment. The payment rates in effect at the time of the disaster will be paid to the evacuated facility for the care of the relocated residents. The Department may establish an interim payment for extraordinary expenses, subject to reconciliation with a retrospective settlement.

4.8522 Retrospective Payment. The Department shall perform a retrospective cost and revenue settlement subsequent to the evacuation period for extraordinary expenses. Payment for extraordinary expenses is contingent upon the facility pursuing all possible sources of revenue, including third party insurance for resident services, property insurance, business interruption insurance and litigation for damages from responsible parties. Payment may be recouped in part or in full if the facility does not make a good faith effort to pursue all possible sources of revenue for extraordinary expenses or if the facility successfully recovers from these sources.

4.853 Revenues. All revenue received from non-Medicaid sources for extraordinary expenses will be used to reduce reported expenses in cost reports during the period of the emergency. Expenses incurred during the emergency will not be allowable for subsequent prospective rate setting activities.

4.854 Short Term Cost Report. The facility shall submit a short term cost report for the period of the evacuation as determined by the Department. The cost report shall include costs associated with the evacuated residents including costs incurred by other service providers as described in Section 4.851.

4.855 Adjusted Patient Days for Rate Calculations after the Evacuation Period. If the base cost report period covered an evacuation period, the calculation of the minimum occupancy test shall be adjusted using the greater of the average occupancy of the three month period prior to the evacuation period or the average occupancy of the three month post-evacuation period for any of the three months following the evacuation period. Patient days for the time period during the evacuation will be deducted from the cost report period. Patient days will then be annualized to obtain the adjusted patient day ratio.

4.856 Bed hold. For bed hold, the criteria in Section 1.500 apply for the three month period following the evacuation except that for the occupancy criteria, the greater of the average patient day occupancy for the three month period prior to the evacuation or the actual for any of the three months following the evacuation period will be used in the bed hold occupancy test.

4.857 Procedure.

A. Normal Rate Setting. A 12 month fiscal year cost report including the evacuation time period shall be submitted by the facility. A separate short term cost report consisting of only the expenses and revenues attributable to the evacuation period shall also be submitted. The short term cost report shall then be subtracted from the 12 month cost report and the remaining costs annualized for normal rate setting purposes.

B. Rate Setting for the Evacuation Period. Expenses from the short term cost report shall have any revenues received as a result of insurance, third party liability, law suits, and related revenue sources for the evacuation offset. The portion of the difference attributable to Medicaid residents in excess of the Medicaid daily payment rates shall then result in additional Medicaid reimbursement.

4.858 Facilities Receiving Residents from Evacuated Certified Nursing Homes.

A. Patient Days. Patient days for residents received from an evacuated facility will not be included in patient days used for normal rate setting unless the residents are permanently admitted to the receiving facility. Occupancy determinations used for the rate calculations for the payment system will use the three months period prior to admission of these temporary residents.

B. Base Cost Report Effect. Base cost reports including the evacuation period will be adjusted for all expenses billed to the evacuated facility or facilities and/or associated with the evacuated residents.

SECTION 5.000 APPENDICES RELATED TO REIMBURSEMENT

5.100 SUPPLIES AND EQUIPMENT

5.110 General. Dietary Supplies, Incontinence Supplies, Personal Comfort Supplies, Medical Supplies and Equipment, and other similar items reasonably associated with patients' personal living needs in normal and routine nursing home operations are to be provided to Medicaid recipient patients without charge to the patient, the patient's family, or other interested persons. Costs for any such durable and non-durable items are considered to be reimbursed in the facility's daily rate and, therefore, not to be billed or paid for separately.

If a Medicaid recipient specifically requests a brand of a non-durable item:

(1) which the nursing home does not routinely supply, AND

(2) for which there is no equivalent or close substitute brand routinely supplied to patients by the facility,

then the recipient will be expected to pay the actual cost of that item out of personal funds, AFTER being informed in advance that there will be a charge for the item. However, if the non-durable item was ordered by a physician, the recipient cannot be charged. (Reference: HFS 107.09(2)(b), Wis. Adm. Code)

The following is a partial list of items covered by Section 5.000. The Department retains its authority under s. 49.45(10), Wis. Stats., to amend, modify, or delete items from the list.

5.120 Dietary Supplies

Artificial sweeteners
Diet supplements (Metrecal, Ensure, Vivonex and related products)
Salt substitutes (Neocurtasal, etc.)
Sugar substitutes

(Note: The cost of dietary supplies is included in the support services allowance.)

5.130 Incontinence Supplies

Catheters (Foley and Condom), catheter sets, component parts, (tubing, urine collection apparatus, e.g., bags, bed bags, etc.)

Diapers - disposable and reusable (including purchased diaper service)

Underpads - disposable and reusable

5.400 DIRECT CARE PAYMENT PARAMETERS

5.410 Labor Factors

County	New Factor	Old Factor	County	New Factor	Old Factor
Adams	1.038	1.084			
Ashland	0.933	0.927	Manitowoc	0.962	0.970
Barron - 547xx	0.962	0.970	Marathon	1.002	0.970
Barron - 548xx	0.933	0.927	Marinette	0.962	0.970
Bayfield	0.933	0.927	Marquette	1.038	1.084
Brown	0.990	0.970	Menominee	0.962	0.970
Buffalo - 546xx	0.933	0.927	Milwaukee	1.093	1.084
Buffalo - 547xx	0.962	0.970	Monroe	0.933	0.927
Burnett	0.933	0.927	Oconto	0.962	0.970
Calumet	0.982	0.970	Oneida	0.933	0.927
Chippewa	0.983	0.970	Outagamie	0.982	0.970
Clark	0.962	0.970	Ozaukee	1.093	1.084
Columbia	1.038	1.084	Pepin	0.962	0.970
Crawford	0.933	0.927	Pierce	1.133	1.084
Dane	1.088	1.084	Polk - 540xx	1.038	1.084
Dodge	1.038	1.084	Polk - 548xx	0.933	0.927
Door	0.962	0.970	Portage	0.962	0.970
Douglas	1.000	0.927	Price	0.933	0.927
Dunn	0.962	0.970	Racine	1.069	1.084
Eau Claire	0.983	0.970	Richland	1.038	1.084
Florence	0.962	0.970	Rock	1.009	0.970
Fond du Lac - 530xx	1.038	1.084	Rusk	0.933	0.927
Fond du Lac - 549xx	0.962	0.970	Sauk	1.038	1.084
Forest	0.933	0.927	Sawyer	0.933	0.927
Grant - 535xx	1.038	1.084	Shawano	0.962	0.970
Grant - 538xx	0.933	0.927	Sheboygan	1.031	1.084
Green	1.038	1.084	St. Croix	1.133	1.084
Green Lake - 539xx	1.038	1.084	Taylor	0.962	0.970
Green Lake - 549xx	0.962	0.970	Trempealeau - 546xx	0.933	0.927
Iowa	1.038	1.084	Trempealeau - 547xx	0.962	0.970
Iron	0.933	0.927	Vernon	0.933	0.927
Jackson	0.933	0.927	Vilas	0.933	0.927
Jefferson	1.038	1.084	Walworth	1.038	1.084
Juneau	1.038	1.084	Washburn	0.933	0.927
Kenosha	0.986	0.970	Washington	1.093	1.084
Kewaunee	0.962	0.970	Waukesha	1.093	1.084
La Crosse	0.982	0.970	Waupaca	0.962	0.970
Lafayette	1.038	1.084	Waushara	0.962	0.970
Langlade	0.962	0.970	Winnebago	0.982	0.970
Lincoln	0.962	0.970	Wood	0.962	0.970

5.420 Case Mix Weights

Level of Care	Case Mix Weight
DD3	1.10
DD2	1.55
DD1B	1.85
DD1A	1.85
ICF4	0.25
ICF3	0.25
ICF2	0.50
ICF1	0.70
SNF	1.00
ISN	1.30
Ventilator	4.00

5.430 Statewide Direct Care Maximum. The statewide direct care maximum is $57.42.

5.440 Statewide Direct Care Cost Inflation Increment. The statewide direct care inflation increment is $2.39.

5.500 SUPPORT SERVICES PAYMENT PARAMETERS

5.510 Support Services Maximum and Increment

Target T1 = $20.50 for common period.
Target T2 = $21.25 for common period.
Increment = $0.75 to adjust costs to payment rate year.

5.550 ADMINISTRATIVE AND GENERAL SERVICES PAYMENT PARAMETERS

5.551 Administrative and General Services Maximums and Increment

Maximum for Providers over 40 beds for rate setting (Section 3.040)	= $10.81
Maximum for Providers with 40 or fewer beds for rate setting (Section 3.040)	= $12.39
Increment	= $ 0.39
P% for the exceptional Medicaid utilization adjustment	= 64.70%
Base Allowance for the exceptional Medicaid utilization adjustment	= $ 0.50

5.600 FUEL AND UTILITY PAYMENT PARAMETERS

5.610 Fuel and Utility Targets. The following fuel and utility expense targets are for the common period.

Target	Counties in Region
Region I = $2.06	Bayfield, Douglas
Region II = $2.04	Ashland, Iron, Oneida, Price, Vilas
Region III = $1.98	Barron, Burnett, Chippewa, Clark, Florence, Forest, Langlade, Lincoln, Marathon, Marinette, Menominee, Oconto, Polk, Rusk, Sawyer, Shawano, Taylor, Washburn
Region IV = $1.95	Adams, Brown, Buffalo, Calumet, Door, Dunn, Eau Claire, Fond du Lac, Green Lake, Jackson, Juneau, Kewaunee, La Crosse, Manitowoc, Marquette, Monroe, Outagamie, Pepin, Pierce, Portage, Sheboygan, St. Croix, Trempealeau, Waupaca, Waushara, Winnebago, Wood
Region V = $1.88	Columbia, Crawford, Dane, Dodge, Grant, Green, Iowa, Jefferson, Lafayette, Richland, Rock, Sauk, Vernon
Region VI = $1.86	Kenosha, Milwaukee, Ozaukee, Racine, Walworth, Washington, Waukesha

5.612 Fuel and Utility Increase Allowance. The inflation factor to adjust payment and expense to the payment rate year shall be 1.0%.